Mental Health Services Act Expenditure Report

Fiscal Year 2006 – 2007

A Report to the Legislature in Response to

AB 131, Omnibus Health Budget Trailer Bill
Chapter 80, Statutes of 2005

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January 2007

Mental Health Services Act Expenditure Report

Fiscal Year 2006 – 2007

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EXECUTIVE SUMMARY

The passage of Proposition 63, the Mental Health Services Act (MHSA) in November 2004 provides an opportunity to increase funding, personnel and other resources to support county mental health programs and monitor progress toward statewide goals for serving children, transition age youth, adults, older adults and families with mental health needs. The MHSA addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support the local mental health system.

The MHSA imposes a 1 percent income tax on personal income in excess of $1 million. The MHSA was projected to generate approximately $254 million in FY 2004-05, $683 million in FY 2005-06, $690 million in FY 2006-07 and increasing amounts thereafter. These were initial estimates of revenue to come from the additional tax. Actual revenues to date have substantially exceeded these early estimates. The actual amount collected for the 2005 tax year will not be known until spring 2007, when 2005 tax return data are available. Refer to Table 1 on pages 6 – 7 entitled "MHSA Estimated Receipts" for revised estimates of available resources based on the Governor's proposed January 2007 Budget.

The MHSA specifies six major components around which DMH has created an extensive stakeholder process to consider input from all perspectives. Because of the complexity of each component, implementation of the six components is being staggered. Proposition 63 expenditures are estimated to be approximately $153.3 million in FY 2005-06 and $494.4 million in FY 2006-07 to continue a phased implementation of the MHSA components.

ISSUE STATEMENT

This report to the Legislature is required by Assembly Bill 131 (Chapter 80, Statutes of 2005), which specifies that the Director of the California Department of Mental Health shall submit to the Legislature information regarding the projected expenditure of Proposition 63 funding for each state department, and for each major program category specified in the measure for local assistance. This shall include actual past-year expenditures, estimated current-year expenditures and projected budget-year expenditures of local assistance funding.

The Department of Mental Health (DMH) submitted its first fiscal report to the Legislature on the Mental Health Services Act (MHSA) for Fiscal Year 2005-06 in January 2006. As required by Assembly Bill 131, in May 2006 the Department submitted an Addendum to the report to coincide with the Governor's Budget Revision. In addition to actual and projected expenditures of funds generated in Fiscal Year 2006-07, this report provides specific information regarding achievements to date and implementation activities planned for FY 2007-08.

BACKGROUND

A broad continuum of prevention, early intervention and service needs are addressed in the MHSA. The Act also provides for and the necessary infrastructure, technology and training elements that will effectively support the local mental health system.

The purpose of the MHSA is to:

- Define serious mental illness among children, adults and seniors as a condition deserving priority attention, including prevention and early intervention services and medical and supportive care

- Reduce the long-term adverse impact on individuals, families and state and local budgets resulting from untreated serious mental illness

- Expand the kinds of successful, innovative service programs for children, adults and seniors begun in California, including culturally and linguistically competent approaches for underserved populations

- Provide state and local funds to adequately meet the needs of all children and adults who can be identified and enrolled in programs under this measure

- Ensure that all funds are expended in the most cost effective manner and services are provided in accordance with recommended best practices, subject to local and state oversight, to ensure accountability to taxpayers and to the public

By imposing a 1 percent income tax on personal income in excess of $1 million, the MHSA was projected to generate approximately $254 million in FY 2004-05, $683 million in FY 2005-06, $690 million in FY 2006-07 and increasing amounts thereafter. These were the initial estimates of revenue to be generated by the additional tax. However, actual revenues to date have substantially exceeded these early estimates. The full amount collected for the 2005 tax year will not be known until spring 2007, when 2005 tax return data are available from the Franchise Tax Board. Table 1 on the following two pages entitled “MHSA Estimated Receipts” provides revised estimates of resources available based on the Governor’s proposed January 2007 Budget.

Table 1: Mental Health Services Act (MHSA) Estimated Receipts
Estimated Based on Governor's Proposed January 2007 Budget
(Dollars in Millions)

	Fiscal Year				
	2004-05	**2005-06**	**2006-07**	**2007-08**	**2008-09**
Total - All Components					
Original MHSA Estimate	**$254.0**	**$683.0**	**$690.0**	**$733.0**	**$784.3**
Revised Estimate					
Cash Transfers	$169.5	$894.6	$945.0	$1,004.0	$784.3
Accrued Revenue from Prior Years	$83.6	$0.0	$0.0	$448.0	$583.0
Interest Income	$0.7	$11.2	$47.3	$71.1	$38.9
Estimated Available Receipts	**$253.8**	**$905.8**	**$992.3**	**$1,523.1**	**$1,406.2**
Community Services and Supports (Excluding Innovation)					
Original MHSA Estimate		**$356.9**	**$360.5**	**$383.0**	**$558.8**
Distribution Percentage from MHSA	0.00%	52.25%	52.25%	52.25%	71.25%
Revised Estimate					
Cash Transfers		$467.4	$493.8	$524.6	$558.8
Accrued Revenue from Prior Years		$0.0	$0.0	$234.1	$415.4
Interest Income		$5.9	$24.7	$37.1	$27.7
Estimated Available Receipts		**$473.3**	**$518.5**	**$795.8**	**$1,001.9**
Innovation for Community Services and Supports					
Original MHSA Estimate		**$18.8**	**$19.0**	**$20.2**	**$29.4**
Distribution Percentage from MHSA	0.00%	2.75%	2.75%	2.75%	3.75%
Revised Estimate					
Cash Transfers		$24.6	$26.0	$27.6	$29.4
Accrued Revenue from Prior Years		$0.0	$0.0	$12.3	$21.9
Interest Income		$0.3	$1.3	$2.0	$1.5
Estimated Available Receipts		**$24.9**	**$27.3**	**$41.9**	**$52.8**
Prevention & Early Intervention (Excluding Innovation)					
Original MHSA Estimate		**$129.8**	**$131.1**	**$139.3**	**$149.0**
Distribution Percentage from MHSA	0.00%	19.00%	19.00%	19.00%	19.00%
Revised Estimate					
Cash Transfers		$170.0	$179.6	$190.8	$149.0
Accrued Revenue from Prior Years		$0.0	$0.0	$85.1	$110.8
Interest Income		$2.1	$9.0	$13.5	$7.4
Estimated Available Receipts		**$172.1**	**$188.6**	**$289.4**	**$267.2**
Innovation for Prevention & Early Intervention					
Original MHSA Estimate		**$6.8**	**$6.9**	**$7.3**	**$7.8**
Distribution Percentage from MHSA	0.00%	1.00%	1.00%	1.00%	1.00%
Revised Estimate					
Cash Transfers		$8.9	$9.5	$10.0	$7.8
Accrued Revenue from Prior Years		$0.0	$0.0	$4.5	$5.8
Interest Income		$0.1	$0.5	$0.7	$0.4
Estimated Available Receipts		**$9.0**	**$10.0**	**$15.2**	**$14.0**

	Fiscal Year				
	2004-05	2005-06	2006-07	2007-08	2008-09
Education & Training					
Original MHSA Estimate	**$114.3**	**$68.3**	**$69.0**	**$73.3**	**$0.0**
Distribution Percentage from MHSA	45.00%	10.00%	10.00%	10.00%	0.00%
Revised Estimate					
Cash Transfers	$76.3	$89.5	$94.5	$100.4	$0.0
Accrued Revenue from Prior Years	$37.6	$0.0	$0.0	$44.8	$0.0
Interest Income	$0.3	$1.1	$4.7	$7.1	$0.0
Estimated Available Receipts	**$114.2**	**$90.6**	**$99.2**	**$152.3**	**$0.0**
Capital & Information Technology					
Original MHSA Estimate	**$114.3**	**$68.3**	**$69.0**	**$73.3**	$0.0
Distribution Percentage from MHSA	45.00%	10.00%	10.00%	10.00%	0.00%
Revised Estimate					
Cash Transfers	$76.3	$89.5	$94.5	$100.4	$0.0
Accrued Revenue from Prior Years	$37.6	$0.0	$0.0	$44.8	$0.0
Interest Income	$0.3	$1.1	$4.7	$7.1	$0.0
Estimated Available Receipts	**$114.2**	**$90.6**	**$99.2**	**$152.3**	**$0.0**
Local Planning					
Original MHSA Estimate	**$12.7**				
Distribution Percentage from MHSA	5.00%	0.00%	0.00%	0.00%	0.00%
Revised Estimate					
Cash Transfers	$8.5				
Accrued Revenue from Prior Years	$4.2				
Interest Income	$0.0	-	-	-	-
Estimated Available Receipts	**$12.7**				
State Administration					
Original MHSA Estimate	**$12.7**	**$34.2**	**$34.5**	**$36.7**	**$39.2**
Distribution Percentage from MHSA	5.00%	5.00%	5.00%	5.00%	5.00%
Revised Estimate					
Cash Transfers	$8.5	$44.7	$47.3	$50.2	$39.2
Accrued Revenue from Prior Years	$4.2	$0.0	$0.0	$22.4	$29.2
Interest Income	$0.0	$0.6	$2.4	$3.6	$1.9
Estimated Available Receipts	**$12.7**	**$45.3**	**$49.7**	**$76.2**	**$70.3**

Original MHSA estimated receipts are from the MHSA (Revenue and Taxation Code Section 19602.5(c)(3)(B)(i)). Revised estimated revenues are prepared twice a year in January and May by the California Department of Finance as part of the State Budget process. The revised estimated receipts encompass a two year period (current fiscal year and budget fiscal year) with subsequent fiscal year estimated receipts based on amounts in the MHSA. Fiscal year 2008-09 estimated receipts are based on a 7 percent growth rate over fiscal year 2007-08 amounts in the MHSA in accordance with Revenue and Taxation Code Section 19602.5(c)(3)(B)(ii). The distribution percentage for each component is from the MHSA (Welfare and Institutions Code Section 5892).

Explanation of Estimated Receipts

The estimated receipts shown in Table 1 represent estimated deposits into the Mental Health Services (MHS) Fund anticipated to occur during the relevant fiscal year which reflects accounting for these receipts on a cash basis. Conversely, the Governor's Proposed January Budget shows revenues when they are earned (regardless of when the funds are deposited) which reflects accounting for revenues on an accrual basis. The chart below provides a comparison between estimated revenues on an accrual basis as per the Governor's Proposed January Budget versus anticipated deposits into the MHS Fund during each fiscal year on a cash basis. Since the Department cannot make funds available until they are deposited into the MHS Fund, Table 1 shows estimated receipts by component on a cash basis.

As shown in the chart below, the cash transfers are the same under either accounting approach. These amounts represent the net personal income tax receipts transferred into the MHS Fund in accordance with Revenue and Taxation Code Section 19602.5(b). The accrued revenue shown in the Governor's Proposed January Budget is not actually deposited into the MHS Fund until two fiscal years after the revenue was earned. Also, the interest earned on monies in the MHS Fund in the fourth quarter of each fiscal year is not deposited into the MHS Fund until the next fiscal year, so the interest income is slightly different on an accrual versus cash basis.

Mental Health Services Act (MHSA) Estimated Receipts
Compared to Governor's Proposed 2007 Budget
(Dollars in Millions)

	Fiscal Year			
	2004-05	**2005-06**	**2006-07**	**2007-08**
Original MHSA Estimate	**$254.0**	**$683.0**	**$690.0**	**$733.0**
Governor's Proposed January 2007 Budget				
Cash Transfers	$169.5	$895.0	$945.0	$1,004.0
Accrued Revenue	$83.6	$448.0	$583.0	$690.0
Interest Income Earned During Fiscal Year	$0.7	$19.9	$53.3	$70.9
Estimated Revenues-Governor's Proposed Budget	**$253.8**	**$1,362.9**	**$1,581.3**	**$1,764.9**
Estimated Receipts-Cash Basis				
Cash Transfers	$169.5	$894.6	$945.0	$1,004.0
Accrued Revenue from Prior Years	$83.6	$0.0	$0.0	$448.0
Interest Income Posted During Fiscal Year	$0.7	$11.2	$47.3	$71.1
Estimated Available Receipts	**$253.8**	**$905.8**	**$992.3**	**$1,523.1**

Components of the MHSA

The MHSA specifies six major components around which DMH has created an extensive stakeholder process to consider input from all perspectives. Because of the complexity of each component, implementation of the six components is being staggered. The stakeholder process involves the development of discussion documents, a series of general stakeholder meetings and topic-specific workgroups to provide input on critical issues, and to advise on implementation policies and processes. Each component addresses critical needs and priorities to improve access to effective, comprehensive, culturally and linguistically competent expanded county mental health services and supports. Improvement in client outcomes is a fundamental expectation throughout the implementation process. The MHSA specifies the percentage of funds to be devoted to each of the components and requires the DMH to establish the requirements for use of the funds.

The components and the required funding percentage specified in the MHSA for FY 2004-05 through FY 2007-08 are:

	Percentage Funding Distribution by Component			
	FY 2004/05	**FY 2005/06**	**FY 2006/07**	**FY 2007/08**
Education/Training	45.0%	10.0%	10.0%	10.0%
Capital Facilities/Technology	45.0%	10.0%	10.0%	10.0%
Local Planning *	5.0%			
Prevention and Early Intervention (PEI)**	0.0%	20.0%	20.0%	20.0%
Community Services and Supports (CSS)**	0.0%	55.0%	55.0%	55.0%
State Implementation/ Administration	5.0%	5.0%	5.0%	5.0%
Total	100%	100%	100%	100%

** Local Planning is a maximum of 5 percent of the total amount distributed during a fiscal year*.

***Includes funds available for Innovative Programs pursuant to Welfare and Institutions Code Section 5892(a)(6)*

- **Community Program Planning Process**—This is an inclusive local process involving clients, families, caregivers and partner agencies to identify community issues related to mental illness and resulting from lack of community services and supports. It also defines the populations to be served and the strategies that will be effective for providing the services, to assess capacity, and to develop the work plan and funding requests necessary to effectively deliver the needed services.

- **Community Services and Supports (CSS)**—"System of Care Services" described in the MHSA is now called “Community Services and Supports.” The CSS are the programs, services, and strategies that are being identified by each county through its stakeholder process to serve unserved and underserved populations, with an emphasis on eliminating disparity in access and mental health outcomes for racial/ethnic populations.

- **Education and Training**—This component targets workforce development programs to remedy the shortage of qualified individuals to provide services to address severe mental illnesses.

- **Capital Facilities and Technological Needs**—This component addresses the capital infrastructure needed to support implementation of the Community Services and Supports and Prevention and Early Intervention programs. It includes funding to improve or replace existing technology systems and for capital projects to meet program infrastructure needs.

- **Prevention and Early Intervention (PEI)**—This component supports the design of programs to prevent mental illnesses from becoming severe and disabling, with an emphasis on improving timely access to services for unserved and underserved populations.

- **Innovation (5 percent of CSS and 5 percent of PEI)**—The goal of this component is to develop and implement promising practices designed to increase access to services by underserved groups, increase the quality of services, improve outcomes and to promote interagency collaboration.

DMH has developed a draft "MHSA Summary Work Plan" to obtain input regarding proposed timelines for implementing all the components of the MHSA. The draft summary work plan is available for download from the MHSA Website at: http://www.dmh.ca.gov/MHSA/docs/FinalMHSAPlan_2-16-07.pdf.

Table 2 on the following page displays actual expenditures for Fiscal Year 2005-06, estimated expenditures for Fiscal Year 2006-07, and projected expenditures for Fiscal Year 2007-08.

Table 2: Proposition 63 Expenditures
January 2007

	Actual FY 05-06	Estimated FY 06-07	Projected FY 07-08
State Support:*			
Department of Mental Health (DMH)	$13,401,280	$19,918,000	$15,086,000
Mental Health Services Oversight and Accountability Commission (MHSOAC)	$496,797	$1,492,000	$1,468,000
Department of Health Services (DHS)	$39,966	$495,000	$579,000
Department of Social Services (DSS)	$400,697	$508,000	$709,000
Department of Education (CDE)	$125,282	$412,000	$722,000
Department of Rehabilitation (DOR)	$119,564	$195,000	$214,000
Department of Alcohol & Drug Programs (DADP)	$191,926	$258,000	$510,000
Managed Risk Medical Insurance Board (MRMIB)	-	$154,000	$156,000
State Controller's Office (SCO)	-	$43,000	$48,000
Total Support	**$14,775,512**	**$23,475,000**	**$19,492,000**
Local Assistance:			
Education & Training	-	-	$294,800,000
Capital Facilities & Technology	-	-	$294,800,000
Local Planning	-	-	-
Prevention**	-	-	$363,500,000
Community Services & Support (CSS) **	$153,308,253	$494,416,000	$540,300,000
Total Local Assistance	**$153,308,253**	**$494,416,000**	**$1,493,400,000**
GRAND TOTAL	**$168,083,765**	**$517,891,000**	**$1,512,892,000**
Prevention & Early Intervention (P/EI)**	-	-	$341,800,000
P/EI Innovation**	-	-	$21,700,000
Total P/EI	-	-	**$363,500,000**
CSS**	$153,308,253	$494,416,000	$453,800,000
CSS Innovation**	-	-	$86,500,000
Total CSS	**$153,308,253**	**$494,416,000**	**$540,300,000**
P/EI Innovation**	-	-	$21,700,000
CSS Innovation**	-	-	$86,500,000
Total Innovation	-	-	**$108,200,000**

* The MHSA allows 5 % of the total annual revenue received for the Fund for state support activities
** Includes funds available for Innovative Programs pursuant to Welfare and Institutions Code Section 5892(a)(6)

DESCRIPTION OF STATE SUPPORT EXPENDITURES

During FY 2005-06, FY 2006-07, and FY 2007-08, eight (8) state departments and the Mental Health Services Oversight and Accountability Commission (MHSOAC) are allocated MHSA funding. Collaborative efforts are funded from state support. The eight departments are the Department of Mental Health (DMH), the Department of Health Services (DHS), the Department of Social Services (DSS), the California Department of Education (CDE), the Department of Rehabilitation (DOR), the Department of Alcohol and Drug Programs (DADP), the Managed Risk Medical Insurance Board (MRMIB), and the State Controller's Office (SCO). Each department is receiving funding as described below. Refer to Table 3 on page 14 for detail on state support funding for FY 2006-07 and FY 2007-08.

- **DMH** (FY 2005-06: $13,401,280; FY 2006-07: $19,918,000; FY 2007-08: $15,086,000): Funding adjustments in FY 2006-07 include an increase in personal services for retirement and employee compensation, as well as a baseline increase in operating expenses. For FY 2007-08, the total funding decreased to a total of $15,086,000 primarily due to an elimination of one-time contract costs of $5,198,000; and a decrease of $1,595,000 for the expiration of 43 limited-term positions. Other adjustments made for the FY 2007-08 budget are referenced in Table 3 on page 14 of this report.

- **DHS** (FY 2005-06: $39,966; FY 2006-07: $495,000; FY 2007-08: $579,000): to support one position to address increased workload as a result of the MHSA, and to support a contract to develop and implement the interdepartmental California Mental Health Disease Management (CalMEND) project. Examination of potential changes in Medi-Cal requirements (including waiver amendments and subsequent program evaluation) to promote consistency with the MHSA vision and values is a primary objective. DHS will work with DMH in coordinating any changes in fee-for-service and managed care policies resulting from the integration of MHSA vision and values with the Medi-Cal Program. Included in FY 2007-08 is a one-time increase of $133,000 to support expansion of the CalMEND project.

- **DSS** (FY 2005-06: $400,697; FY 2006-07: $508,000; FY 2007-08: $709,000): to support four positions for training and technical assistance to address the proposed expansion of comprehensive services to maintain children and youth with serious emotional disturbance (SED) in their homes.

- **CDE** (FY 2005-06: $125,282; FY 2006-07: $412,000; FY 2007-08: $722,000): to support three positions and contract funds to design, develop and present training to county and district school staff to help them identify mental illness and increase access to mental health services for students who have been diagnosed with SED.

- **DOR** (FY 2005-06: $119,564; FY 2006-07: $195,000; FY 2007-08: $214,000): to support two positions to serve as North and South regional liaisons for training, technical assistance and support for local collaborative efforts to identify

opportunities for cooperative programming and services with county mental health and education agencies.

- **DADP** (FY 2005-06: $191,926; FY 2006-07: $258,000; FY 2007-08: $510,000): to support two positions, one to focus on prevention issues and the other on treatment. They will help provide coordination and technical support in implementing collaborative and innovative programs that link mental health and alcohol and other drug prevention and treatment services at the local level.

- **MRMIB** (FY 2005-06: $0; FY 2006-07: $154,000; FY 2007-08: $156,000): to support one position to ensure effective coordination of services and collaboration between all the stakeholders, including providers and administrators, providing services to children who are SED in the Healthy Families Program (HFP). This funding also supports an independent evaluation/survey to evaluate the service delivery systems used to provide mental health services and substance abuse treatment services to children who are SED and enrolled in the HFP.

- **SCO (Human Resource Management System)** (FY 2005-06: $0; FY 2006-07: $43,000; FY 2007-08: $48,000): to support the new Human Resource Management System (HRMS)/Payroll system, also known as the 21st Century Project, which replaces the existing SCO employment and payroll systems. The new HRMS is expected to improve business practices and streamline administrative operations. Special fund sources are assessed their share of the cost of developing the systems to implement the newly required business process changes.

- **MHSOAC** (FY 2005-06: $496,797; FY 2006-07: $1,492,000; FY 2007-08: $1,468,000): Funding adjustments in FY 2006-07 include an increase in personal services for retirement and employee compensation, as well as a baseline increase in operating expenses. For FY 2007-08, adjustments include an elimination of one-time operating expenses.

Table 3: Department of Mental Health
State Support
Fiscal Years 2006-07 and 2007-08

	Fiscal Year 2006-07
Personal Services	$6,971,000
Operating Expenses	$1,717,000
Contracts	$10,616,000
Total	**$19,304,000**

The following adjustments are reflected in the 2007-08 Governor's Budget for Fiscal Year 2007-08	**Fiscal Year 2007-08**
One-time costs eliminated from the Fiscal Year 2007-08 Budget	
Operating Expenses	-$36,000
Contracts	-$5,198,000
Total one-time costs from Fiscal Year 2007-08 Budget	-$5,234,000
Limited Term Positions Expired*	-$1,595,000
Total Decreases	**-$6,829,000**
Increases:	
Personnel/Labor Relations BCP	$108,000
Retirement	$59,000
Employee Compensation	$379,000
Operating Expenses Statewide Surcharge	$131,000
ProRata Adjustment	$1,740,000
Operating Expenses Price Increases	$194,000
Total Increases	**$2,611,000**
Budget Year Total	**$15,086,000**

*This table excludes $1.5 million in 2006-07 and 2007-08 for the MHSOAC

Adjusted Current Year Totals	**Fiscal Year 2006-07**
Total from above	$19,304,000
Retirement Drill (Personal Services)	$59,000
Employee Compensation Drill (Personal Services)	$424,000
Operating Expenses Statewide Surcharge	$131,000
Current Year Total	**$19,918,000**

ACHIEVEMENTS DURING FY 2006-07

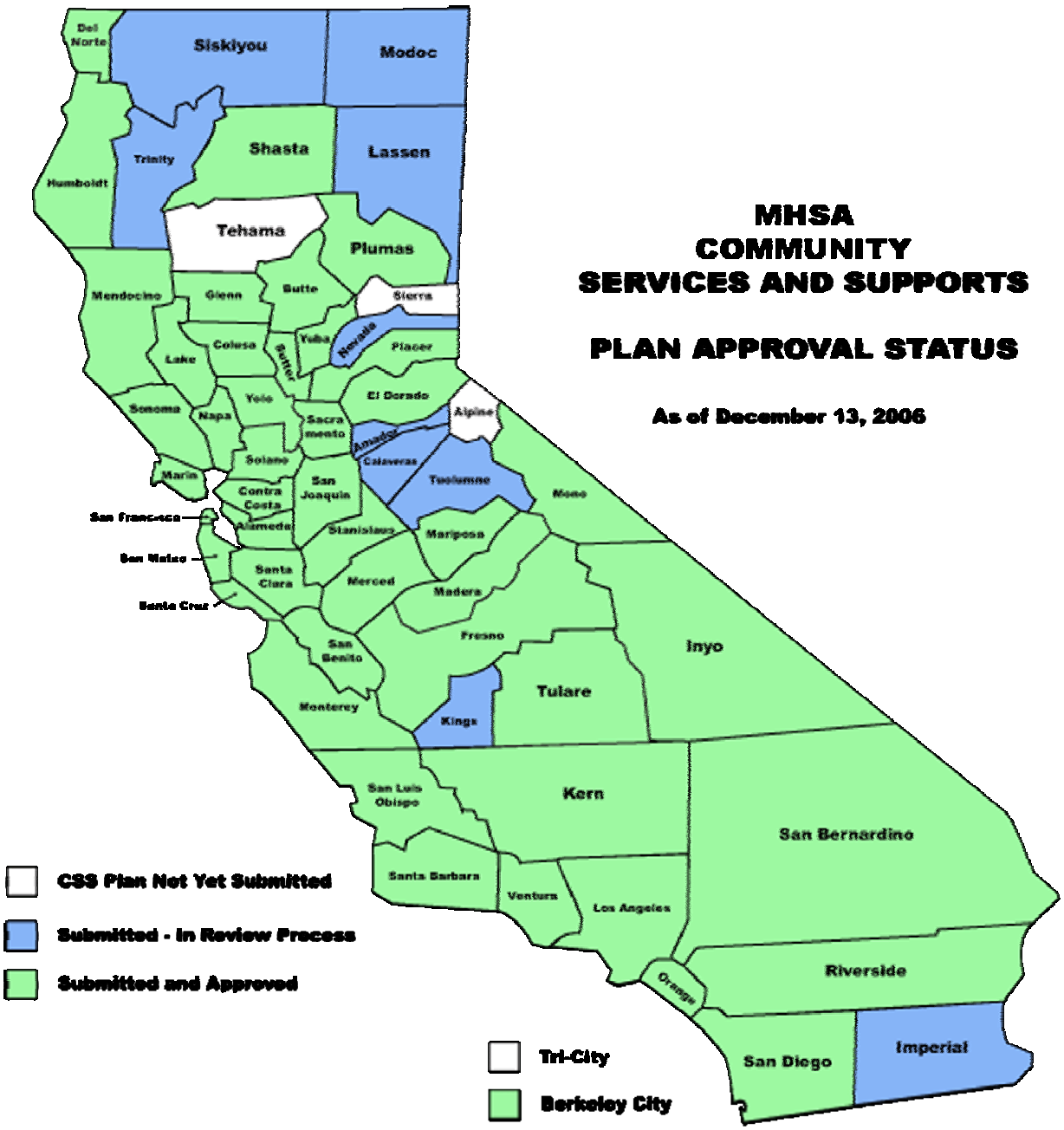
Stakeholders Process

Since passage of the Mental Health Services Act in November 2004, the DMH has committed to an extensive and transparent stakeholder process, beginning with its first General Stakeholders Meeting held in December 2004. As of January 2007 the DMH has convened twenty three (23) general and workgroup-specific stakeholders meetings and eighteen (18) statewide conference calls. Since December 2004 more than two thousand eight hundred (2,800) stakeholders in total have attended the various general and workgroup-specific stakeholders meetings. In addition the Department has continued to encourage stakeholders to provide input on MHSA-related issues and policies through the general MHSA email address, the toll-free MHSA phone line and the MHSA Website.

Community Services and Supports

Community Services and Supports (CSS) refers to "System of Care Services" as required by the MHSA in Welfare and Institutions Code Sections 5813.5 and 5878.1 to 5878.3. The change in terminology differentiates MHSA Community Services and Supports from existing and previously existing System of Care programs funded at the federal, state and local levels. The MHSA requires that “each county mental health program shall prepare and submit a three-year plan which shall be updated at least annually and approved by the Department of Mental Health after review and comment by the Oversight and Accountability Commission.” The MHSA further requires that “the department shall establish requirements for the content of the plans.” Annual updates of the county three-year plan will be required pursuant to MHSA requirements. The requirements for the content of the plans and the emergency regulations can be located on the DMH Website at: http://www.dmh.ca.gov/mhsa.

The DMH developed plan requirements for the Program and Expenditure Plan for CSS with stakeholder participation in early 2005 and released them in final August 1, 2005. No specific due date was provided for counties to submit their Program and Expenditure Plan, and as of November 2006, fifty five (55) county plans have been received and forty five (45) plans have been approved for funding (see MHSA Community Services and Supports Plan Approval Status Map on the following page).


MHSA
COMMUNITY
SERVICES AND SUPPORTS
PLAN APPROVAL STATUS
As of December 13, 2006
Del Norte
Siskiyou
Modoc
Humboldt
Trinity
Shasta
Lassen
Tehama
Plumas
Mendocino
Glenn
Butte
Sierra
Colusa
Yuba
Nevada
Placer
Lake
Sutter
Yolo
El Dorado
Sonoma
Napa
Sacramento
Alpine
Amador
Solano
Calaveras
Marin
Tuolumne
Mono
Contra Costa
San Joaquin
San Francisco
Alameda
Stanislaus
Mariposa
San Mateo
Santa Clara
Merced
Madera
Santa Cruz
Fresno
Inyo
San Benito
Tulare
Monterey
Kings
San Luis Obispo
Kern
San Bernardino
Santa Barbara
Ventura
Los Angeles
Riverside
Orange
San Diego
Imperial
CSS Plan Not Yet Submitted
Submitted - In Review Process
Submitted and Approved
Tri-City
Berkeley City

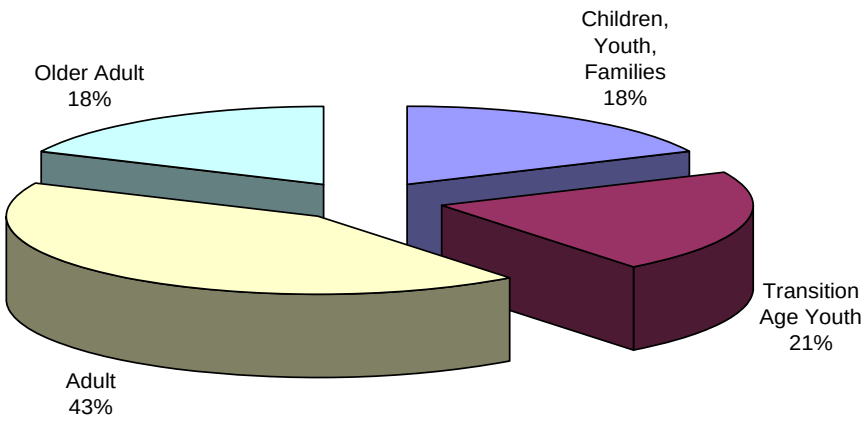
An estimated $1.79 billion[1] will be available over the three-year period from July 2005 through June 2008 to support the implementation of Community Services and Supports, which includes $473.3 million for FY 2005-06 and $518.5 million for FY 2006-07. Uncommitted funds from FY 2005-06 and 2006-07 will be used to establish county prudent reserve accounts, as provided for in the MHSA, and future year service expansions.

Below and on the following pages are pie charts reflecting proposed expenditures from county Community Services and Supports Three-Year Program and Expenditure Plans submitted to date. The five charts display proposed expenditures by geographic region and statewide by age group (Adults; Older Adults; Children, Youth and Families; and Transition Age Youth).

Mental Health Services Act
Community Services & Support

Three-Year Program and Expenditure Plan[1] - Fiscal Year 2005/2006 through 2007/2008
Proposed Expenditures by Age Group as of October 16, 2006

Bay Area[2]



[1]From the initial submission of the Three Year Program & Expenditure Plan, prior to State review.
[2]Represents 12 of 12 county programs in the Bay Area Region.

[1] This figure does not include CSS Innovation.

Mental Health Services Act
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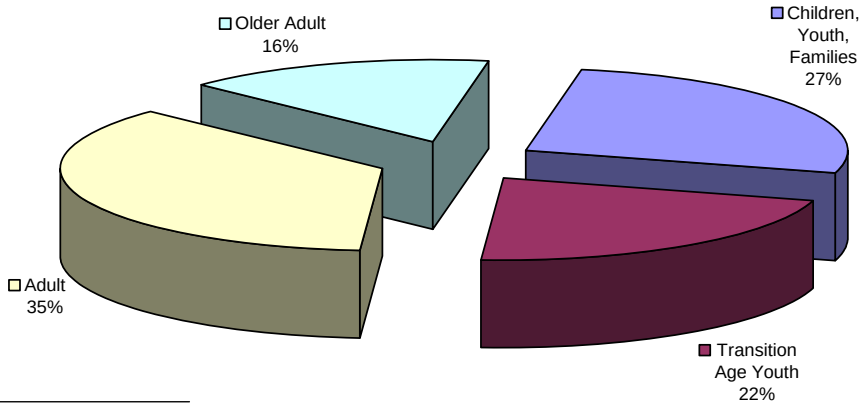
Central Valley[2]



[1]From the initial submission of the Three Year Program & Expenditure Plan, prior to State review.
[2]Represents 15 of 18 county programs in the Central Valley Region.
[3] Mariposa & Calaveras Counties divided Proposed Expenditures by 2 Age Groups instead of 4. Estimated funding per each group was based on average ratios for the Region.

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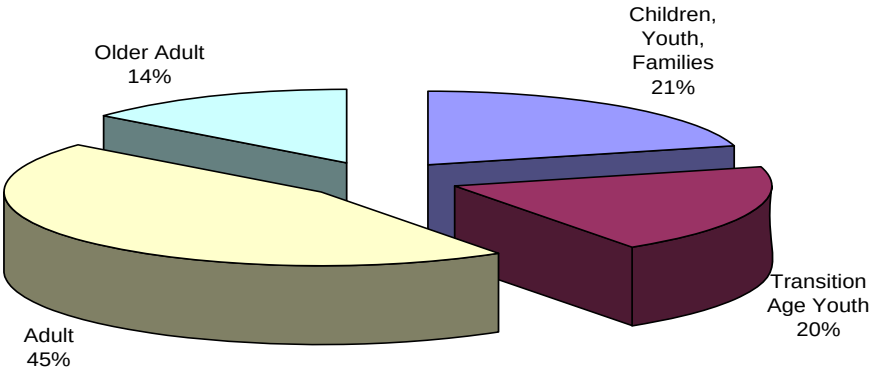
South & Los Angeles[2]



[1]From the initial submission of the Three Year Program & Expenditure Plan, prior to State review.
[2]Represents 10 of 11 programs in the Southern California and Los Angeles Regions.

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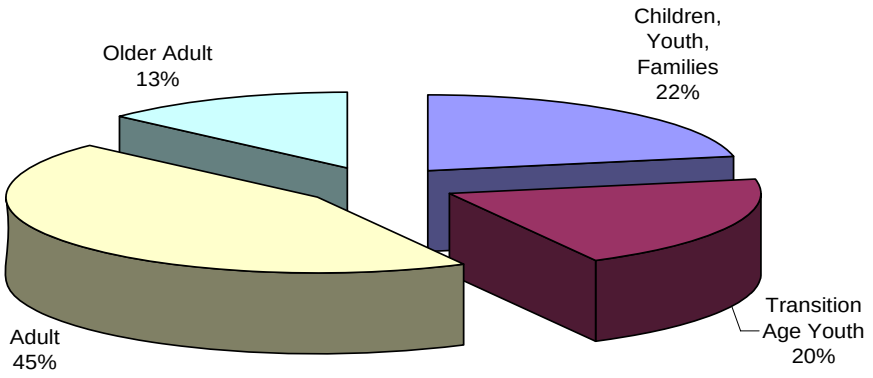
Superior[2]



[1]From the initial submission of the Three Year Program & Expenditure Plan, prior to State review.
[2]Represents 14 of 17 counties in the Superior Region.

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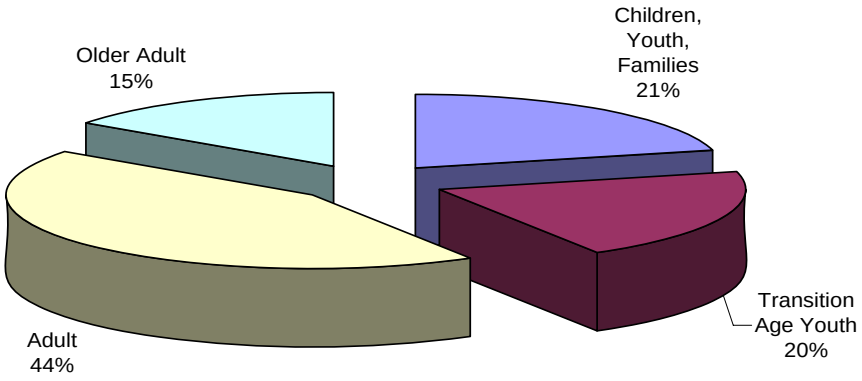
Statewide[2]



[1]From the initial submission of the Three Year Program & Expenditure Plan, prior to State review.
[2] Represents 52 of 58 County Programs Statewide.

Governor's Homeless Initiative

The Governor's Homeless Initiative (GHI) created a housing finance model that ties together California Housing Finance Agency (CalHFA) debt financing, tax credits, and capital subsidies. The GHI was established as a result of the passage of Proposition 46 and leverages MHSA funds to encourage development of supportive housing projects that target chronically homeless individuals with serious mental illness. This Initiative offers a non-traditional centralized loan and application approval process. Approximately $3.15 million from MHSA funds in FY 2005-06 were set aside for this Initiative, with $2 million designated for rental subsidies, $750,000 designated for pre-development costs and $400,000 distributed to establish supportive housing development collaboration at the local level.

The focus on collaboration at the local level has been initiated with the implementation of DMH sponsored Regional Housing Trainings. There have been eleven (11) trainings conducted throughout the State. The goal of these activities is to bring together county mental health departments, county housing agencies, housing developers and community-based service providers to share expertise and leverage resources to develop more housing opportunities for homeless people with serious mental illness. County mental health departments are a fundamental component of this effort to maximize housing options for individuals eligible for services under the MHSA, and they must provide a long-term commitment to fund supportive services for a project to qualify for approval under the Governor's Homeless Initiative. At this time eight (8) applications have been submitted for funding under the GHI Program, two (2) of which have received approval for funding and the remainder of which are under review.

Training

The MHSA requires the DMH to provide technical assistance and training to county mental health departments. Due to the aggressive timeline for conducting this process, it was critical that consultants with extensive background and knowledge of the DMH and county mental health program issues assist with the development of training principles and products. DMH issued a contract to the California Institute for Mental Health (CiMH) as they have this level of expertise and collaborative working relationship with the local county mental health departments.

Over the past year CiMH has provided several rounds of regional trainings for counties on MHSA Planning, Housing Data and Building Housing Collaboratives, as well as regional trainings for the Mental Health Boards and Commissions. A series of regional trainings on Project Management was initiated at the end of the fiscal year and will continue into next year. The agency also provided training for medical directors and physicians to assist them in providing leadership in the MHSA implementation process. A series of Webcasts was conducted that focused on specific programmatic interventions for each of four age groups, including evidence-based and promising practices.

Trainings targeted mental health directors, MHSA coordinators, direct service staff from counties and community agencies, consumers, family members, stakeholders from the community and other agencies such as housing agencies and developers. For several trainings, including MHSA planning, Building Housing Collaboratives and Project Management, counties were encouraged to bring teams of staff and stakeholders, including community provider staff and consumers and family members, so that the team could begin to develop strategies and action plans that could be implemented on return to their counties. CiMH incorporated consumers and family members into the planning of the trainings and technical assistance and contracted with them to provide training.

In all, there were twenty five (25) face-to-face trainings serving over one thousand (1,000) participants and thirty nine (39) Webcasts serving over three thousand (3,000) participants, a total of sixty four (64) trainings serving over four thousand (4,000) participants, from fifty six (56) local mental health authorities (counties and cities).

The trainings and technical assistance:

- Provided counties information instrumental to their planning and implementation
- Offered mental health departments an opportunity to begin work with potential collaborators, e.g., housing agencies and developers
- Presented Mental Health Advisory Board/Commission members an opportunity to learn about MHSA, the implementation of MHSA and the role of the boards and commissions in the planning/approval process
- Provided medical directors strategies for participating in the implementation of MHSA
- Provided MHSA coordinators with tools to organize the MHSA implementation process

CiMH continues to develop trainings and technical assistance based on the needs of the State and the counties in the MHSA implementation process.

CONTINUING IMPLEMENTATION ACTIVITIES IN FY 2006-07 and FY 2007-08

In 2007, the DMH plans further implementation efforts for the following MHSA components: Education and Training, Capital Facilities and Housing, Information Technology, Outcomes Reporting, Prevention and Early Intervention and Innovation.

Education and Training

In the Education and Training component, the MHSA specifies that each county mental health program shall submit to the DMH a needs assessment identifying shortages in each professional and other occupational categories and a plan to increase the supply of professional and other staff that county mental health programs anticipate they will require. DMH is required to identify the total statewide needs for each professional and other occupational categories and develop a five-year education and training development plan.

The DMH formed an MHSA Workforce Education and Training unit that is responsible for facilitating and supporting the public planning process and the writing and administering of the Five-Year Plan. This unit works with the Human Resources Committee of the California Mental Health Planning Council and the Education and Training Committee of the Oversight and Accountability Commission to execute the statutory requirements of the Act for approval and oversight of the Five-Year Plan.

The MHSA Workforce Education and Training unit held a public stakeholder process. During a series of statewide forums, the public had the opportunity to provide input on what was needed and how to address California's workforce education and training challenges.

A statewide advisory body was formed that includes leaders and subject matter experts. This advisory body assisted in the formation of twelve special topic workgroups. Each workgroup focuses on one of the objectives outlined in the Five-Year Plan and is responsible for crafting a series of recommended actions for public consideration. Each workgroup is comprised of a cross-section of individuals representing county mental health, contract agencies, educational institutions, professional organizations and consumers and family members.

Having obtained input on workforce needs from mental health stakeholders, DMH analyzed workforce data and challenges contained in the Community Services and Support (CSS) plans. This analysis has been published and is available on the DMH Website. DMH has also developed a comprehensive needs assessment work plan and, in partnership with stakeholders, is currently in the process of developing a comprehensive needs assessment methodology.

In order to address the immediate needs brought about by implementing the initial CSS Plans, DMH has asked training experts to expand their capacity in order to provide assistance in implementing services in accordance with the vision and values of the

Mental Health Services Act. DMH added MHSA funding to its existing statewide contracts with trainers and consultants who have a proven track record of providing training and technical assistance as envisioned by the Act and who could immediately address training and workforce needs on a statewide basis. These contracts are in the following areas:

- **Organizational Change Support –** The California Institute for Mental Health (CiMH) expanded its existing statewide training and technical assistance mission of supporting county mental health programs. This expansion included ongoing technical assistance for organizational development toward consumer and family member-driven, evidence-based service delivery as envisioned by the Act, and to facilitate regional learning collaborative networks to plan and implement new practices.

- **Financial Incentive Program –** The California Social Work Educational Consortium (CalSWEC) expanded its existing stipend program to provide financial incentives for students in masters level social work programs committed to working in community public mental health. One hundred seventy-three (173) graduates are now available for employment this year. This program provides a replicable model for development of additional financial incentive programs.

- **Statewide Constituency Partnership –** The statewide constituency organizations of the California Network of Mental Health Clients (CNMHC), United Advocates for Children of California (UACC), and the National Alliance for the Mentally Ill – California (NAMI) are expanding their efforts to reach consumers and family members with self-help technical assistance and train-the-trainer curricula, such as Educate, Equip and Support – Building Hope, Peer-to-Peer, Family-to-Family, and Wellness Recovery Action Planning. These curricula will promote the meaningful inclusion and employment of consumers and family members at all levels of the public mental health system.

In Fiscal Year 2007-08, the DMH will continue efforts initiated in FY 2006-07 to implement the actions outlined in the Education and Training Five-Year Plan. Approximately $456.3 million will be generated through June 2008 to support the development and implementation of a Five-Year Education and Training Plan.

Capital Facilities

The MHSA specifies that a portion of the funds generated by the MHSA is to be used for capital facilities and technological needs to support community-based integrated services. This component addresses the capital infrastructure needed to support implementation of the Community Services and Supports (CSS) and Prevention and Early Intervention (PEI) Plans. MHSA funds have been specifically set aside for capital facilities and technology in fiscal years 2004-05 through 2007-08 to enable counties to implement their CSS and PEI Plans, and in subsequent fiscal years

counties may use a portion of their MHSA CSS funding for capital facilities and technology needs.

Capital facilities may include housing and other buildings that enable clients with mental illnesses to live in the most independent, least restrictive housing possible in their local community and to receive services in community-based settings that support wellness, recovery and resiliency. DMH is currently drafting the guidelines for capital facilities expenditures with an anticipated release scheduled for early 2007. The release of the proposed guidelines will be followed by an opportunity for statewide stakeholder feedback and recommendations as part of the process for establishing the final requirements for the counties.

Mental Health Services Act Housing Program

In May 2006 Governor Schwarzenegger issued Executive Order S-07-06. This order states that up to $75 million per year of the MHSA Capital Facilities funds will be dedicated to develop permanent supportive housing for individuals with mental illness and their families, with special emphasis on homeless individuals. This effort builds on the interagency collaboration established in November 2005 with the Governor's Homeless Initiative. Executive Order S-07-06 directs DMH to continue this collaboration with the California Housing Finance Agency (CalHFA) and the Department of Housing and Community Development (HCD) to develop and implement this program for individuals eligible for services under the MHSA. The MHSA Housing Program guidelines are currently under development by a technical committee comprised of representatives from state agencies, county mental health, housing development entities and policy experts on homeless issues. Proposed program guidelines will be released for stakeholder input in early 2007. Safe, affordable housing is fundamental to helping individuals with mental illness and their families stabilize their lives and this new program blends both the capital and services commitments that maximize opportunities for recovery.

Technological Needs

The MHSA provides funding for county technology projects that will improve the access and delivery of mental health services to the public. The DMH is responsible for ensuring that the MHSA funds are appropriated to county technology projects that are consistent with MHSA goals and objectives, and that are well-planned, well-managed and executed properly. In order to allocate funds appropriately, the DMH created a process in which counties submit their technology funding requests for approval in accordance with established DMH guidelines. The DMH then works directly with each county technology representative (usually the chief information officer) to develop a comprehensive understanding of the technology project and the anticipated results, and make any required modifications prior to approval. Once the approval is granted, funds are released to the county in support of the project. The DMH then continues to work in an oversight capacity with the county in order to ensure the project's success. During

FY 06-07, the DMH approved sixteen (16) technology funding requests and released a total of $7,600,080 for county technology projects.

The DMH technology goal for MHSA is to transform county and local mental health technology systems into an accessible, interoperable and comprehensive information network that can 1) easily and securely capture, exchange and utilize information, and 2) facilitate the highest quality, cost-effective services and supports for consumer and family wellness, recovery and resiliency. To promote this technology transformation, the DMH is developing minimum statewide standards for mental health Electronic Health Record (EHR) systems. These standards will specify increasingly complex requirements so that counties and their vendors will be able to adapt their systems while meeting their current business needs. In addition, the future requirements will maintain alignment with national standards setting organizations such as Health Level 7 (HL7), the Certification Commission on Healthcare Information Technology (CCHIT) and the Healthcare Information Technology Standards (HITSP).

Key to reaching the DMH technology goal is the implementation of a Health Information Exchange (HIE) architecture that makes health information available to consumers and providers of mental health services throughout California. To facilitate this objective, DMH is pursuing the concept of a Mental Health Information Exchange "Agent" through which all county EHR systems are interconnected. The Agent will house consumer demographic information, locations of previous services, and critical health care information for continuity of care purposes. County providers, hospital emergency departments, laboratories, pharmacies and consumers, via the "My Health Folder," could all access and exchange information through the Agent.

In 2007, the DMH will release two Requests for Information (RFIs). The first RFI will assist counties in determining which vendors are interested in providing California compliant EHR systems for mental health. The second RFI will identify vendors interested in providing the Agent functionality for interoperability between counties and other entities based on the requirements for HIE. Finally DMH will draft regulations to enforce the ongoing adherence to technology standards for the improvement in quality data reporting.

Prevention and Early Intervention

The MHSA authorizes the DMH to establish program requirements for Prevention and Early Intervention (PEI) in California. In addition, the MHSA authorizes the Mental Health Services Oversight and Accountability Commission (MHSOAC) to approve program expenditures for PEI. Because of this unique relationship, the DMH and the MHSOAC are working closely to craft the program and funding requirements. The MHSOAC approved its proposal for PEI principles and funding criteria in October 2006. At this time the MHSOAC, the DMH, the California Mental Health Directors Association and the California Mental Health Planning Council are collaborating to develop principles, guidelines, funding priorities and outcome measures.

In addition to the collaboration of the government partners, the DMH plans to conduct statewide stakeholder meetings in 2007 to solicit input on the draft PEI program requirements. A parallel process for obtaining input from underserved and ethnic communities will be implemented through a contract with the U.C. Davis Center for Reducing Health Disparities.

Innovation

The goals for the Innovation funding are to increase access to underserved groups; to increase the quality of services, including better outcomes; to promote interagency collaboration; and to increase access to services.

The MHSA authorizes the DMH to establish program requirements for Innovation component. In addition, the MHSA authorizes the Mental Health Services Oversight and Accountability Commission (MHSOAC) to approve the Innovation program expenditures. Because of this unique relationship, the DMH and the MHSOAC are working closely to craft the program and funding requirements for the Innovation component. The MHSOAC has convened an Innovation Committee which is in its early stages of developing working definitions of Innovation, Innovation Need and Innovative Response. This work will culminate in the development of an Innovation Proposal to be presented and approved by the MHSOAC by September 2007. DMH has the responsibility for reviewing local plans; the MHSOAC will have primary responsibility for approving the plans for the Innovation component. It is anticipated that the Innovation component will be operational in FY 2007-08.

Outcomes Reporting

Counties that have received Community Services and Supports plan approval are in various stages of implementing MHSA-funded programs and providing services, with a number of counties reporting Full Service Partnership (FSP) outcomes and other MHSA services information. In addition, all counties with approved CSS plans have begun submitting Quarterly Reports of targeted and actual numbers of persons outreached and served through the MHSA FSP, outreach and engagement, and system development funding sources. The DMH is creating streamlined data entry, consolidation and analytic processes for statewide aggregation and reporting of this information.

The Measurement and Outcomes Committee of the Mental Health Services Oversight and Accountability Commission (MHSOAC), which includes the Chief of the Evaluation, Statistics and Support branch within DMH, continues to work towards informing, guiding and assisting in the prioritization of performance measurement targets and methods for various aspects of MHSA implementation. In 2007 the Performance Measurement Advisory Committee (PMAC) will focus on furthering the development of measurement protocols for the mental health system's transformation targeting individual client, program/system and community level evaluations. The State Quality Improvement Council (SQIC) is also aligning its quality improvement

goals and projects with the MHSA vision, and is coordinating its activities with the PMAC and other mental health quality endeavors, internal and external to DMH.

Because performance measures selection includes the consideration of technology options available to improve workflow processes, data quality and the feasibility of data collection, DMH information technology personnel, performance measurement personnel and numerous stakeholders statewide continue to collaborate towards enhancing information management infrastructures that support performance measurement and accountability reporting. To that end, the DMH has developed the Data Collection and Reporting system (DCR) and other Web-based data entry processes which streamline the data submission and reporting process for Full Service Partnership programs and other MHSA strategies.

Oversight and Accountability Commission

The Mental Health Services Oversight and Accountability Commission was established in July 2005. The Commission recommends policies and strategies to further the vision of transformation and address barriers to systems change, as well as providing oversight to ensure funds being spent are true to the intent and purpose of the Mental Health Services Act. In this capacity the Commission has been working collaboratively with the Department of Mental Health, the California Mental Health Planning Council, the California Mental Health Directors Association and other key partners.

The Commission has drafted an eighteen (18) month Work Plan covering the period January 1, 2007 through June 30, 2008, which spans FY 2006-07 and FY 2007-08. It is intended to be a blueprint to satisfy all of the above-stated objectives. It proposes an MHSOAC mission, it defines the MHSOAC core roles and responsibilities as specified in the Act, identifies Commission goals consistent with the Act, spells out long-term strategies and short-term activities and suggests an organizational structure to fulfill the Commission's responsibilities and implement its strategies.

The proposed mission statement of the MHSOAC is to provide the vision and leadership, in collaboration with clients, their family members and underserved communities to ensure Californians understand mental health is essential to overall health and to hold public systems accountable and provide oversight for eliminating disparities, promoting mental wellness, recovery and resiliency, and ensuring positive outcomes for individuals living with serious mental illness and their families.

The Roles and Responsibilities of the MHSOAC include:

- In collaboration with clients, family members and underserved communities, provide the vision, leadership and oversight necessary to prevent mental illness from becoming severe and disabling and transform the public and private systems charged with providing services, care and support to Californians living with mental illness

- Oversee the implementation of MHSA Parts 3 and 4, Community Services and Supports (Adults, Older Adults and Children's System of Care); Part 3.1, Human Resources; Part 3.2, Innovative Programs; and Part 3.6, Prevention and Early Intervention. Hold the State and county departments of mental health accountable for developing and implementing transformative programs

    - Review and comment on the Community Services and Support, Capital and Information Technology and Education and Training components

    - Review, comment and approve expenditures in MHSA county as well as statewide plans for Prevention and Early Intervention and Innovation

- In collaboration with clients, family members and underserved communities, develop strategies to combat and overcome stigma

- Advise the Governor and/or the Legislature regarding actions the State may take to improve care and services for individuals experiencing mental illness

- Ensure transparency of the MHSA in planning, implementation and outcomes

- Develop additional and necessary strategies to accomplish any objective or provision of the MHSA. Include clients, families and underserved communities in development of strategies

The MHSOAC will adopt four (4) key strategies to fulfill its roles and responsibilities and achieve its mission. Key strategies remain consistent from year to year. The four key MHSOAC strategies being proposed are:

1. Ensure transparency of the Mental Health Services Act through communication with and education of the public

2. Provide oversight over the Mental Health Services Fund and ensure accountability to the intent and purpose of the MHSA by:

    a. Reviewing and providing comment on Community Services and Supports, Education and Training and Capital and Information Technology Plans. For these plans, provide transformation principles and implementation strategies to DMH to include in local plan requirements

    b. Assisting the DMH in developing county and statewide plan requirements for PEI and Innovation; review, comment and provide final approval on county and statewide plan expenditures in PEI and Innovation Plans

3. Establish expectations for statewide outcomes accountability

4. Develop and advance a statewide policy agenda that promotes systems transformation